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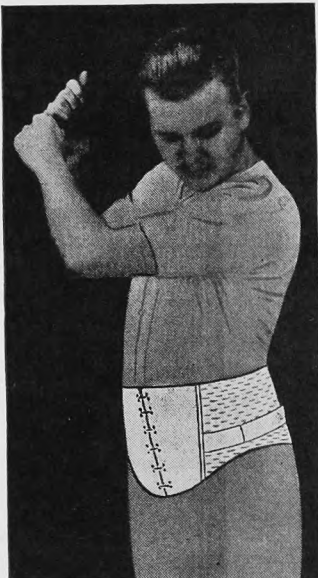
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The Manitoba Medical Association Review

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Clinical Section

Traumatic Shock and Burns*

By

JOHN A. HILLSMAN, M.D. (Virg.), Ch.M. (Man.)

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Professor of Surgery, University of Manitoba

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It may seem a little strange to you that we have grouped together the subjects of traumatic shock and thermal burns. The reason becomes quite apparent when it can be demonstrated beyond reasonable doubt that the underlying factors responsible for clinical shock are the same as those responsible, to a large extent, for the phenomena associated with thermal burns. In fact one may state with assurance that the primary and secondary stages of the burn phenomena are identical with primary and secondary shock. The study of thermal burns, therefore, is best approached through the study of traumatic shock.

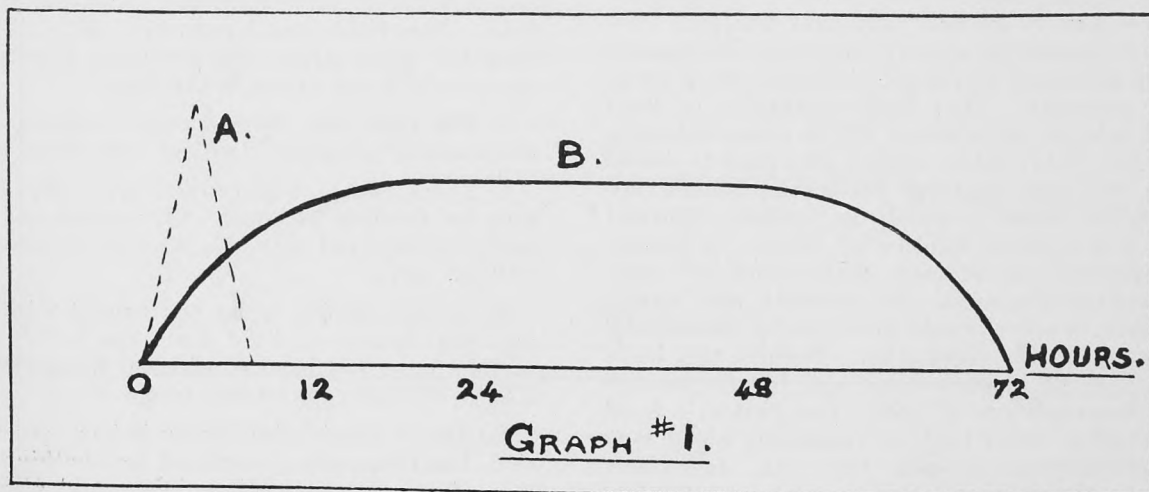
Traumatic Shock.

If one was to ask any group of medical men, engaged in scientific conclave, the definition and cause of traumatic shock he would receive a great variety of answers. There is probably no subject in medicine on which the physiologists hold more divergent views. One could listen for hours to the various physiologists explain the adrenalin secretion theory or the histamine toxin theory as full length monographs have been written on each of these subjects. One would find himself utterly bewildered by the manifest truth of each of these theories to such an extent that the first conclusion would be that the whole subject is entirely too

intricate for a mere clinician. If, however, one is willing to separate the theoretical from the practical the whole problem becomes exceedingly simple. Admitting that any or all of these various theories may be right or that they may be the starting point or the "trigger point" at which the phenomena of shock begins, in the final analysis and from the purely clinical viewpoint shock may be defined as a simple reduction of the total blood volume.

This reduction may be brought about in one of two ways. First, a relative reduction, in which the actual blood volume remains the same while the containing blood vessels enlarge. This phenomena is observed in so-called primary shock, is reflex in origin and is due to pain and fright. Second, an actual reduction in the total blood volume in which the fluid within the vessel is lost, either into inter-cellular spaces, the fascial planes, the body cavities, or to the external environment. This phenomena is observed in secondary shock or so-called "delayed shock." It may be caused by a massive hemorrhage from torn vessels or by the capillaries in the involved area becoming more pervious and exuding fluid into the tissue spaces. The relationship of these two types of shock can easily be seen by graph No. 1.

The research underlying this conception of clinical shock has been done by several groups of investigators. Outstanding in this work has been the basic research of Blalock and his associates. This group of investigators anaesthetized dogs and produced shock by two varieties of trauma. First, by traumatizing a single extremity of the dog and secondly by gentle traction on the animal omentum over a period of time. In the first instance the animal was bisected at the level of the umbilicus. The fluid content of the traumatized and the untraumatized leg was compared both quantitatively and qualitatively. The difference in quantity represented the fluid lost through capillary leakage. In the second instance the fluid lost into the intestinal wall and into the



* Paper read at the Post-Graduate Course on Traumatic Surgery, Medical College, University of Manitoba, February, 1938.

peritoneal cavity was recovered, measured and analyzed. The conclusions reached can be briefly summarized as follows—

1. In the anaesthetized animal primary shock could not be produced as the pain and fright factors were absent.

2. There is an increased permeability of the capillaries in the traumatized area which caused fluid to leak slowly out into the inter-cellular spaces and fascial planes in both the immediate and adjacent areas.

3. The fluid lost occurred concurrently with a fall of blood pressure. It amounted to 3.5% of the animal body weight when the systolic pressure had fallen to 70 mm. of mercury. Using a 150 lb. man as an average, this fluid lost would amount to 1800 cc. or 36% of the total blood volume.

4. The fluid lost by chemical analysis is for all practical purposes identical to blood serum.

5. Using burn trauma upon the animal extremity gave identical results in all respects to other varieties of trauma.

Bearing in mind that the shock phenomena is caused by a lowering of the total blood volume the symptomatology is quite logical. The blood pressure falls and the pulse rate reflexly rises. The peripheral vessels contract to preserve the fluid left for the more important internal organs and the skin becomes pale, cold and clammy. The peripheral temperature is likewise lowered and the organism calls for fluid in the form of an intractable thirst. It may be stated clinically that any patient with a blood pressure below 100 systolic is a potential shock case and that a blood pressure of 70 systolic is definite serious shock.

Treatment.

The fundamental principle of the treatment of shock is the restoration of the blood volume. This is accomplished by the intravenous injections of an adequate quantity of fluid. The quantity of fluid is adequate only when the blood pressure has been restored to normal and fluid therapy should be pushed, no matter what the quantity, until this is accomplished. Bearing in mind that the 150 lb. man loses 1800 cc. before the blood pressure reaches 70 systolic and that the fluid loss does not necessarily stop at this point, the amount of fluid necessary will in all probability be a much larger quantity. That large quantities of fluid can be injected quite safely will be discussed later. Since the fluid lost is almost identical to blood serum the fluid used for restoration should approach this liquid as closely as possible. Normal saline is a common solution of choice. It cannot be emphasized too strongly that colloid in a form of blood transfusion or gum acacia is also vitally necessary, in order to hold the saline by its colloidal action within the circulation. Besides this basic restoration of blood volume and blood pressure other measures are of aid. The patient's head is lowered in order that the remaining blood may be concentrated around the vital medullary centers. Morphine in large doses is given to elim-

inate pain and induce tranquility of mind. Heat is applied in the form of warm blankets and hot water bottles to restore body temperature. The use of adrenalin in primary shock is valuable but in secondary shock its value is dubious.

Thermal Burns.

In taking up the subject of thermal burns one must attain the viewpoint that a burn is, after all, only a form of trauma applied as a rule over a larger area of body surface. Since this is true it naturally follows that more capillaries are involved, the fluid lost is greater in quantity and the mortality is higher. Almost paralleling the work of Blalock and his associates Underhill, Kapsinow and Fiske have very definitely proven all of these premises. Using anaesthetized dogs as the experimental animal these investigators burned one extremity of the animal and compared it both quantitatively and qualitatively with the opposite unburned extremity. Very definite and surprising results were obtained. Stated briefly these are—

1. In the anaesthetized animal the primary shock seen in the clinical case could not be induced. The conclusion is, therefore, that this primary shock is reflex in origin, due to pain and fright, is caused by capillary dilatation and is a relative reduction of the total blood volume.

2. Immediately following the burn the involved capillaries are rendered more pervious to fluid. There is a slow leakage of fluid as a result into the inter-cellular spaces, the fascial planes and onto the body surface where it is lost by drainage and evaporation.

3. This fluid loss is progressive for 24 hours, is stationary for 24 hours and is then slowly re-absorbed.

4. Transposing from the experimental animal to the theoretical 150 lb. man, the quantity of fluid lost in the first 24 hours with 1/6th of the body surface burned would amount to 3500 cc. The fluid lost furthermore was directly proportional to the surface area burned. Therefore with 1/3 of the body surface burned the 150 lb. man would lose 7000 cc. of fluid in 24 hours and with 2/3 of his body surface burned 14,000 cc. of body fluid. This fluid would naturally not only come from the blood stream but would be drawn from the cells of every organ in the body.

5. The fluid lost, by chemical analysis, is for all practical purposes identical with blood serum.

6. There is no re-absorption from the burned area for the first 24 hours. Strychnine and other solutions injected into this area were absolutely without effect.

Is it any wonder when confronted with these amazing figures of fluid loss that a 10% body surface burn has been considered dangerous and a 66 2/3% burn invariably fatal?

So far in considering burns it has been shown that the phenomena observed are nothing more than the usual traumatic primary and secondary

shock. However, there is another factor in the burn phenomena. Every burn, by virtue of the very nature of the injury, is immediately sterile. By the time, however, that excited parents have smeared some form of grease over the area and the patient has been transported to the hospital where he is usually placed upon unsterile sheets, the burn area is teeming with bacteria. All burn cases can be stated to be contaminated and even under the most exacting local treatment a high percentage develop infection. So added to the primary and secondary shock a bacterial toxin may enter the picture as soon as sufficient time has passed for infection to supervene. Thus we can define the three stages of burns (chart 2). First primary shock due to pain and fright caused by capillary dilatation and a relative reduction of the total blood volume. Second, delayed shock due to fluid loss and attended by actual reduction of the total blood volume. Third, bacterial contamination, which in the high percentage of cases becomes infection after a period of incubation, and causes bacterial toxicity.

Up to this point I have not discussed in detail anything about the so-called protein toxin or "histamine-like" toxin. I do not believe in the existence of such a toxin in either shock or burns. This opinion is, I believe, now shared by the majority of clinicians for the following reasons.

1. Blalock and Underhill's experiments account quite adequately for all the phenomena observed and the protein toxin is therefore not necessary.

2. Underhill has proven that the protein toxin could not act in the first 24 hours of the burn phenomena because re-absorption does not take place from the site of injury for that period. Unfortunately Blalock did not investigate the problem of re-absorption.

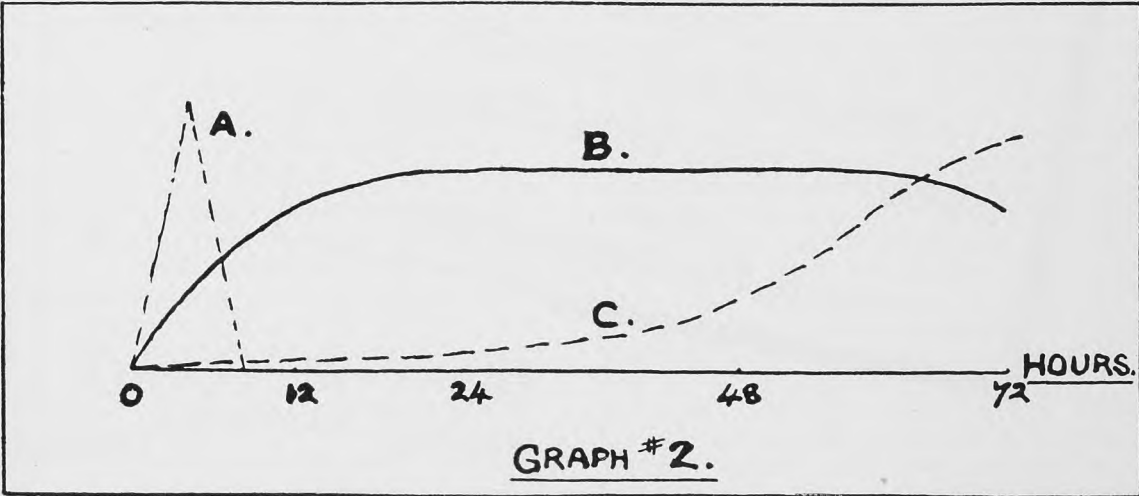
3. Both Underhill and Blalock, using modern technique, obtained negative results in repeating all the early experiments tending to prove the existence of the protein toxin.

There are, however, still quite a large group who refuse to acknowledge that the protein toxin does not exist. Even if this toxin's existence

could be proved it would not detract from the dehydration theory of traumatic shock and thermal burns. The protein toxin would have to act in some way to lower the blood pressure and it may be that it does act by rendering the local capillaries more pervious. After all no one has any idea that can be definitely proven as to the mechanism by which the involved capillaries are rendered more permeable.

In the treatment of the severely burned case it cannot be too strongly emphasized that the systemic treatment is of far more importance than the local treatment. Since the systemic treatment is entirely directed at the restoration of the blood volume and consists of the intravenous injections of amazingly large quantities of fluid the question of the safety immediately arises. If the patient's cardio-renal apparatus is normal any quantity of isotonic saline can be injected into the circulation without harm. Mendell's experiments proved this conclusively. Placing a cannula into a dog's vein and catheters into its ureters this investigator pumped isotonic saline rapidly into the circulation. He found that the dog would take into its inter-cellular spaces a quantity equal to its blood volume. After this point of saturation was reached the fluid ran out of the catheters as fast as he pumped it into the vein. It is to be strongly emphasized that the animal must have a normally functioning cardio-renal apparatus. If heart or kidney damage is present, intravenous therapy is exceedingly dangerous. In the first 24 hours in the burn case it can be reasonably assumed that one is dealing with a normal heart and kidney. After 24 hours autopsy frequently shows cloudy swelling of the kidney. It is absolutely necessary that the systemic treatment of burns therefore be given in the first 24 hours because after that only oral fluids are safe.

Treatment. On admission to the hospital the clinical patient is usually in severe primary shock. He should be given immediately an intravenous injection of a quantity of isotonic saline equal to his total blood volume. It has been proven that the organism can safely store this amount. This should rapidly bring the blood pressure, due to



the relative reduction of the blood volume, back to normal. When vascular tone is restored and the circulatory apparatus has returned to its normal dimensions this fluid will be present in excess to aid in combating the secondary shock now developing. The secondary shock should likewise be treated with intravenous saline. The amount of saline to be given should be gauged by taking the haemoglobin reading every 2 hours during the first day. Intravenous therapy should be pushed, no matter to what quantity, until the haemoglobin percentage is stabilized within its normal limits. This cannot be done with any degree of ease unless some form of colloid is given along with the saline solution. This colloid is best given in the form of either gum acacia or repeated blood transfusions.

Besides the use of intravenous therapy, the primary shock should also be treated by lowering the head of the patient. Heavy dosages of morphine are given to decrease pain and fright and external heat is applied to the body. The latter can best be obtained by the use of carbon lamps within a crib.

The local treatment of burns is likewise important. The use of some agent precipitating protein is still in vogue. Formerly these precipitating agents were used with the idea of fixing the theoretical protein toxin within the burned area to prevent its absorption. At the present time these same agents are used but for a different purpose.

In precipitating the animal protein we are practicing chemical debridement and thus combating the possibility of subsequent infection. Besides this, the eschar undoubtedly gives considerable relief from pain. The precipitating agents now in use are 5% to 10% aqueous solution of tannic acid sprayed on the burned area at frequent intervals until a blackish thick eschar is formed or 1% aqueous solution of gentian violet sprayed on in a similar manner until a thick purple eschar is formed. The gentian violet has some advantage in being more antiseptic and in having a greater degree of pliability to its eschar than tannic acid. Recently attempts have been made to render the tannic acid solution more antiseptic by painting the burned area with 1% silver nitrate before spraying.

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Annual Meeting of Manitoba Medical Association

Preparations are already under way for the Annual Meeting of the Manitoba Medical Association. The exact date has not yet been decided, but it will probably be within the last two weeks in September. The Executive Committee are attempting to make arrangements for speakers to attend from Eastern Canada, including officials from the Canadian Medical Association, and for this reason it will be necessary to make some mutual arrangements with the Alberta Medical Association and the British Columbia Medical Association.

Some groups have made tentative preparations for class reunions at the time of the Annual Meeting, and it is hoped that others may do the same.

Any members wishing to submit papers or who have suggestions to offer as to subjects that they would wish to see discussed either during the clinical sessions or at the annual general meeting, are requested to communicate with the secretary. It is the purpose of the Executive to make the clinical meetings as practical and useful as possible. As there are several important problems of medical organization and medical economics to be discussed, more time will probably be devoted this year to the business of the annual general meeting.

Re Federation

As it will be seen from the minutes of the last meeting of the Executive Committee of the Manitoba Medical Association, the question of the proposed federation of the Provincial and the Canadian Medical Associations was discussed with Dr. T. C. Routley during his visit to Winnipeg.

This scheme of Federation has been discussed for sometime now and it is understood that it is to be brought up at the Annual Meeting of the Canadian Medical Association in June at Halifax. The Committee on Federation of the Manitoba Medical Association is to consider the problem and make a report for the next meeting of the Executive Committee.

This is a problem of importance to every practitioner for it involves the broad question of the relationship between the Provincial Medical Associations and the Canadian Medical Association. At present the link between these Associations is rather a loose one, and under the proposed scheme of Federation the relationship would amount to amalgamation. Apart from the necessity of considering the details of a scheme of such importance, the basic difficulty of the position of health matters under the British North America Act has to be taken into consideration. At the present time health matters are primarily the responsibility of the Provinces, under the Act.

Pregnancy Survey in Manitoba

In the near future it is expected that the physicians of Manitoba will receive a form upon which a record of each case of pregnancy and confinement which they may attend, may be kept. These pregnancy record forms are comprehensive and it is hoped not too cumbersome; they are the outcome of considerable study by the Committee on Maternal Welfare of the Manitoba Medical Association and the Department of Health of Manitoba.

In the past, Maternal Welfare Committees in Provincial Medical Associations as well as in the Canadian Medical Association, have been groping around endeavoring to make recommendations that will help to eliminate maternal deaths. However, facts without which no real progress can be made, have been missing. The proposed pregnancy survey in this province is to collect definite facts and figures. Manitoba has been chosen for this survey for various reasons. There are available for study urban and rural populations, organized and unorganized territories, people of many racial origins, and groups where there has been intermarriage of different racial types. Further, it has been found possible to arrange that the administrative costs of such a survey shall be met by the Rockefeller Foundation, Dominion and Pro-

vincial Departments of Health, at the same time that the general morbidity survey is being done.

Members of your Maternal Welfare Committee felt it would be unfair to ask already underpaid physicians to fill in the pregnancy record questionnaires accurately without some remuneration—fifty cents is probably the maximum fee which can be secured for filling in each form.

If the Manitoba Department of Health and Public Welfare, under whose auspices this survey will be undertaken, has our co-operation and help, the data and facts secured will be invaluable. Every birth in Manitoba for one or two years, will be recorded. It will be the first and most comprehensive study of its kind made anywhere. Though the members of your Maternal Welfare Committee would like to see a larger fee paid for completion of the pregnancy records, they hope every physician in the province practicing obstetrics will endeavor to co-operate and help in every way to make this pregnancy survey a success and the information obtained worth while.

Committee on Maternal Welfare,

MANITOBA MEDICAL ASSOCIATION.

Debate on State Medicine at Ottawa

On March 7th, 1938, a motion in favor of state medicine was introduced in the House of Commons at Ottawa by Rev. Daniel McIvor (Fort William). He summed up his arguments in the following words:—

“Knowing that Canadian health is Canadian wealth, we cannot afford to trifle with the physical and mental well-being of our citizens. In other words, it costs more not to have state medicine than to have it.”

This speaker was followed by Dr. J. P. Howden (St. Boniface). Following are excerpts from his remarks:—

“Mr. Speaker, if the motion requires a seconder, I should like to take that privilege.

“What is state medicine? A great deal has been said in the United States and in Canada in the last ten years about state medicine, but I believe I have never seen the term defined. In fact, a questionnaire directed to Doctor Routley, Grand Secretary of the Canadian Medical Association, brought this response:

The Canadian Medical Association has not adopted any official definition of the term ‘state medicine’ but it is my view that the council would likely be in agreement upon the following definition:

By state medicine is meant a system of medical administration by which the state provides medical services for the entire population, or a large group thereof, and under which all practitioners are employed, directed and paid by the state, on a salary basis.

“I should say it would be sufficient to define state medicine as provision by the state or government for the medical care of the sick.

“This definition would be broad enough and elastic enough to fit any set of conditions, from the mere payment of medical fees to a medical man for services rendered to the state, to the complete medical service such as, so far, we see in only one part of the world—to me, the ideal condition—namely, state medicine as it is practised in Russia.

“Is state medicine desirable? I ask the question, and seek to answer it in the affirmative, under three headings. I would say, yes, first because it would limit the spread of infection and the incidence of death, and, second, because it would eliminate the uneven distribution of the cost of medical services to the people. May I put it in another way: it would afford an adequate system of medicine to the wage earner and the low salaried man. The third reason is that it would take up the slack between outlying districts, where there are no doctors, and the idle doctors which are to be found in comparative abundance in any urban centre.”

The motion was opposed by Dr. H. R. Fleming of Humboldt, supported by Mr. J. S. Woodsworth, Winnipeg North Centre, and discussed by several other members.

The resolution was opposed by the Hon. C. G. Power, Minister of Pensions and National Health. The following excerpts are taken from his remarks:

“To a layman confronted with a resolution of that kind, the first difficulty is to get a real definition of the terms employed. I have listened carefully during the afternoon in order to understand exactly the definition of state medicine, at least in the minds of many of those discussing it.

“I thought it advisable, as a layman, to seek counsel from those who might be best qualified to know, so I asked some of the officers of my department to telegraph to the secretary of the Canadian Medical Association to ask him what definition he would give of state medicine. This definition has already been quoted by the hon. member for St. Boniface this afternoon. It is as follows:

“Canadian Medical Association has not adopted any official definition of the term state medicine, but it is my view that council would likely be in agreement upon the following definition. By state medicine is meant a system of medical administration by which the state provides medical services for the entire population or a large group thereof and under which all practitioners are employed, directed and paid by the state on a salary basis.

“That is to say, state medicine would be a system whereby medical service would be available to all citizens, and all the medical workers—if I may so express myself—doctors, nurses, dentists, orderlies, etc., would be paid and directed by the state.

“On the other hand we have been talking this afternoon of a system described as health insurance, which is cognate to state medicine. But health insurance differs from state medicine, as

I understand it, in that it implies a contribution of some kind by the beneficiary and does not necessarily mean that the doctor or medical worker will be in the employ of the state. So the definition I am told should be this, that state medicine means free treatment of all citizens, with payment of the doctors by the state, whereas health insurance means treatment of those who have contributed, by doctors paid, either by fees or on a capitation basis, to look after people who intend to be beneficiaries under the scheme.

"In Great Britain where, it has been stated, a system of state medicine obtains, there is no state medicine, but there is a widely developed scheme of health insurance which covers something like 19,000,000 workers.

"Now I come to state medicine proper. Under any definition which I have been able to obtain, state medicine exists in only one country in the world, that is in Russia.

"I suppose that what we must next consider is whether state medicine as they have it in Russia could be adopted in this country. I doubt very much whether the people of Canada would stand for it, and I do not think the Minister of Health has the authority under the British North America Act to shoot the doctors in this country. I fear it would be impossible to establish any absolute and complete system of state medicine without first taking some steps to liquidate a great many members of the medical profession. I doubt whether the medical profession as such is in favour of such a system. As a matter of fact the Canadian Medical Association has strongly disapproved state medicine although, as I said at the beginning of my remarks, I believe it approved health insurance.

"In a country like ours, with a climate such as we have, the most equable climate in the world; with a people sprung from the sturdiest stocks in Europe; with scientists at least as learned as those in any other country; with universities producing young men who are capable of leaving Canada and holding high positions throughout the world—with all these advantages we can achieve a great deal. But I believe that we can achieve it less by regimentation as it exists in some other countries than by co-ordination of our people in the way of science and by co-ordination of the work of the universities and of government. I believe we can succeed less by coercion and more by co-operation among all those bodies, municipal, provincial and federal who wish to bend their energies towards the task of making this a better and a healthier nation. The Federal Department of Health is ready and willing to do its share."

The remarks collected above are taken from the Hansard, unrevised edition. One of the interesting points arising out of the debate was the apparent confusion in the minds of some of the speakers as to what constituted state medicine. It was evidently confused with health insurance in some cases. The position seemed to be clarified by the remarks of the Hon. Mr. Power, the Minister of Pensions and National Health.

Proposed Amendment to the Medical Act in Ontario

Under the heading of "An Attack on the Medical Act" there appears in the Bulletin of the Ontario Medical Association for March, 1938, the following article:

"The Medical Act of this Province has been regarded as an admirable example of legislation which is fashioned to protect the public against the ignorant and dangerous activities of those unqualified in the field of the healing arts. The Ontario Medical Act in its present form was passed in 1897 and, though it has been amended on several occasions, all of these changes tended to raise the standard of qualification to practise medicine in this province. We are now confronted with the announcement that the Ontario Academy of Osteopathy and the Associated Chiropractors and Drugless Therapists of Ontario will apply for an Act to amend the Medical Act by adding to Subsection 2 of Section 49, the words—'nor to any Chiropractor, Drugless Therapist or Osteopath registered under the Drugless Practitioners Act.'

Section 49 now reads as follows:

(1) Any person not registered pursuant to this Act, who takes or uses any name, title, addition or description implying or calculated to lead people to infer that he is registered under this Act, or that he is recognized by law as a Physician, Surgeon, Accoucheur, or licentiate in Medicine, Surgery or Midwifery or who assumes, uses or employs the title 'Doctor,' 'Surgeon' or 'Physician' or any affix or prefix indicative of such titles as an occupational designation relating to the treatment of human ailments, or advertises or holds himself out as such, shall mean a penalty of not less than \$25 nor more than \$100.

(2) Subsection (1) shall not apply to any licentiate of dental surgery or any other person admitted to practise dentistry or dental surgery under the provision of 'The Dentistry Act' nor to any person registered as a pharmaceutical chemist under 'The Pharmacy Act' (Ontario Medical Act, 1925).

The effect of the proposed amendment would be to permit these persons registered under the Drugless Practitioners Act to assume the title 'Doctor' and to afford them equality of status in the eyes of the public with qualified practitioners of medicine. The consequences of this step are too serious to be regarded with equanimity. The public deserves and must have the ability to distinguish between those adequately trained in medicine, surgery and midwifery and those inadequately trained individuals whose field of activity is confined to the support of the manipulative cults. No lesser standard than the full medical course and the subsequently licensing examination should be accepted as a qualification to use the designation 'Doctor' with all that it connotes in the public mind.

The Association and the College of Physicians and Surgeons will jointly make representations

against this proposed amendment at the Private Bills Committee, but the support of every doctor in the province is necessary if this retrograde step is to be defeated."

The only section of the Medical Act of Manitoba comparable to that in the Ontario Act is Section 79. "Any person who wilfully or falsely pretends to be a physician, doctor of medicine, surgeon or general practitioner, or assumes any title, addition or description other than he actually possesses and is legally entitled to, shall be liable to a penalty not exceeding fifty dollars nor less than ten dollars." In the Ontario Act the title "doctor" is specifically mentioned.

The Margaret Scott Nursing Mission

By

MRS. GERTRUDE C. CODE, *President*

The Margaret Scott Nursing Mission grew out of the desire of a woman to give care and help to the sick poor. For two years Margaret Scott worked unceasingly in all parts of the city, amongst all creeds and all nationalities. Her friends realized that the work was beyond the strength of one woman and Mrs. Scott saw that these people needed more than she could give them, trained nursing care was necessary and so the Margaret Scott Free Nursing Mission was born. With the single exception of Toronto, Winnipeg was the first Canadian city to pay out money for the salary of a District Nurse.

Public meetings were held, churches were approached, Civic, Provincial and Dominion bodies were made cognizant of the plights of those who could not get or did not require hospital care.

Help was given quickly, generously and willingly. A Charter was drawn up and a constitution compiled by lawyers who gave freely of their time. Two Boards were appointed, the Advisory made up of men and the Directors of women, the churches sent delegates who automatically became members of the first Board. Several are still active members.

At once "a scheme was proposed to secure a house that will answer as a central home for the nurses to which application can be made, clothing and subscriptions sent." And so 99 George Street was purchased. From Margaret Scott herself in 1904 with one nurse assisting making 6,937 calls, we have grown to a staff consisting of a superintendent and five registered nurses, some with special training to their credit making 15,900 calls in 1937.

In addition to the permanent staff four student nurses from the Winnipeg General and two from the Children's Hospital come to the Mission, living there for eight weeks when they get training and experience in this nursing service.

During the present year a group of nurses from the Victoria Hospital were given demon-

strations on the nursing of obstetrical cases in the home. Also two nurses who were going to do work in country districts, were sent by the Department of Health of the Province to attend demonstrations in home nursing of maternity cases.

There is no accommodation for patients and no clinic. All the work is done in the homes.

From the very beginning the Mission worked in close co-operation with the Winnipeg General Hospital. This co-operation cannot be stressed too strongly, the Hospital had paid the salary of a District Nurse for three years, then Mrs. Scott carried on for a short time alone until a friend provided the salary for a registered nurse.

The work grew as the capacity of the Hospital was taxed beyond its limits. In the typhoid epidemic the Margaret Scott Nursing Mission relieved the situation by giving free nursing care in the homes. As today the Mission Nurses were sent to suspects of infantile paralysis and asked to send reports to the doctors.

The doctors too realized the value of this free care for the sick poor, one expressing himself thus, "In no way could the city care for its poor so economically or so effectively as through such an organization."

The Mission has always worked in close co-operation with the medical profession and is striving to attain a higher efficiency in order to meet the requirements of the profession and so give an improved service to the community.

We are deeply indebted to the Advisory Committee of five doctors who helped to draw up and gave their approval to the standing orders now in use at the Mission.

Cases come to the Mission from doctors, from neighbors, from other agencies or from a member of the family.

No call is ever refused, no case is ever treated without the doctor's advice. Frequently these cases require the help of other agencies and they are notified of this at once.

During the past year ending December 31st, 1937, the nurses made a total of 14,787 visits to 2,111 cases, and in addition visits of investigation, etc., brought the grand total of visits up to 15,900. Some of the cases visited were:

Ante partum	357
Post partum	2,079
Newborn	2,175
Confinements attended	176
Visits to patients on married unemployment relief	2,236
Chronic cases	4,012

The nurses go about their tasks giving with their nursing care a loving sympathy, a warm friendliness and serving all "In His Name."

Executive Meeting

Minutes of a special meeting of the Winnipeg members of the Executive Committee of the Manitoba Medical Association held in the Medical Arts Club on Friday, March 11th, 1938, at 6.00 p.m.

Present.

Dr. C. W. Burns	Dr. S. G. Herbert
(Chairman)	Dr. A. S. Kobrinsky
Dr. W. G. Campbell	Dr. E. L. Ross
Dr. W. W. Musgrove	Dr. Digby Wheeler
Dr. E. S. Moorhead	Dr. C. W. MacCharles
Dr. O. C. Trainor	(Secretary).

Guests.

Dr. F. D. McKenty, Dr. G. S. Fahrni, Dr. T. C. Routley (Secretary of the Canadian Medical Association).

The Chairman explained the meeting was called for the purpose of meeting Dr. T. C. Routley, Secretary of the Canadian Medical Association, who was passing through Winnipeg. There were various questions which Dr. Routley wished to discuss with the Executive Committee.

Federation.

After passing a comment on the minutes which were published in the December issue of the *Review*, it was again explained to Dr. Routley just why we considered these minutes as justified.

Dr. Routley then proceeded to discuss some of the details of the amended draft of the constitution of the Canadian Medical Association, stating that in his opinion it was very much improved.

Article V. This has been changed so that each provincial medical association would be recognized as a branch of the Canadian Medical Association as at present, but that it could become a Division by the method provided in the By-Laws.

Under Article IX. of the proposed constitution, members of the Nominating Committee of the Canadian Medical Association will be members of the Council.

Under Article XIV. no provision of the constitution and by-laws will interfere with a Division as a provincial body, and in addition to being known as a Division of the Canadian Medical Association, e.g., Canadian Medical Association, Manitoba Division, it may also be known as the Provincial Association e.g., Manitoba Medical Association. He pointed out that Alberta and Quebec decided to give up the provincial association name, but some provincial associations may not wish to do this.

Chapter 1—Entirely new.

Any provincial association which is now a branch of the Canadian Medical Association may become a Division as outlined in Chapter V. of the Constitution, and enjoy all the rights and privileges of a Division in the following manner—

(1) By intimating to the Canadian Medical

Association in writing that it desires to become a Division.

- (2) By agreeing to amend where necessary its Constitution and By-Laws to place them in harmony with the Constitution and By-Laws of this Association.
- (3) By agreeing to collect from all of its Divisional members who desire to be members of The Canadian Medical Association such annual fee as may from time to time be set for membership and remit same to this Association.
- (4) By agreeing to take such steps as seem to the Division proper to increase membership in the Association.

With regard to Section 2, he pointed out that the Canadian Medical Association had certain Standing Committees and it would be necessary for the Provincial Division to set up a similar list of committees.

With regard to Section 3, it is believed that the fee for the Canadian Medical Association can be reduced to \$8.00, for it is hoped by Federation to increase the membership of the Canadian Medical Association, and it is felt that this can best be done with the co-operation of the Provincial Divisions.

Chapter 2, Section 2. Various classes of members are provided for. Members at large will be members of the Canadian Medical Association without being members of the local Division, e.g., if the Manitoba Medical Association became the Canadian Medical Association Manitoba Division, a member might wish to join the Canadian Medical Association without joining the Manitoba Medical Association. Under these conditions his application to the Canadian Medical Association would have to be approved by the Manitoba Medical Association, that is, by the Canadian Medical Association, Manitoba Division.

Under Chapter 4, machinery must be provided in the Constitution of the provincial association for appointing a representative on the Nominating Committee of the Canadian Medical Association. If for any reason this nominee should be unable to act on the Nominating Committee through absence or through being proposed for an office such as a president, a member to take his place on the Nominating Committee will be elected from the floor by the Council, and the Chairman of the General Council shall, if necessary, give the casting-vote.

Dr. Trainor suggested that two names might be proposed by the provincial association, one as the first choice and the second as an alternative in case the first could not act. Dr. Routley objected that the two names would be confusing, but Dr. Trainor pointed out that one would be known clearly as the nominee and the second as an alternative. Various members took part in this discussion and were in agreement with Dr. Trainor's suggestions, and the President of the Manitoba Medical Association also agreed with this suggestion.

Dr. F. D. McKenty, Chairman of the Committee on Federation of the Manitoba Medical Association, then discussed the problem. He pointed out that the machinery for discussing this proposed constitution of the Canadian Medical Association seemed to be rather involved, e.g., he was Chairman of the Committee of the Manitoba Medical Association and had never received copy of a draft from the Canadian Medical Association; he presumed that a copy would be sent to the Manitoba Medical Association. He suggested that possibly some of the overlapping might be avoided by appointing Dr. Fahrni, who was a member of the Canadian Medical Committee on Federation, to the Manitoba Medical Committee on Federation. Dr. Fahrni explained that he had only two or three months ago been advised that he was to act on this Committee of the Canadian Medical Association, and read the correspondence from the Chairman of the Committee and Dr. Routley with regard to this matter. Dr. Routley suggested that Dr. Fahrni might get in touch with the Committee on Federation of the Manitoba Medical Association.

The Chairman suggested that this problem could be discussed at the next executive meeting of the Manitoba Medical Association.

It was suggested by Dr. Trainor that representatives on the Canadian Medical Committees should be nominated by the provincial medical associations, and in this way it would be certain that they were in touch with the provincial association and were in a position to represent their views on the problems concerned. Dr. Routley advised that this procedure had been adopted in the past but that it was found more expedient for the Executive Committee of the Canadian Medical Association to appoint the members of the Committees for the Canadian Medical Association, because there was sometimes delay in the provincial associations nominating their members.

Date of Annual Meeting.

Dr. Routley pointed out that three of the western provincial associations, Manitoba, Alberta and British Columbia, would be holding their Annual Meetings in the autumn, and it was hoped that a speaker could be provided for the three meetings, and that also the President and Secretary of the Canadian Medical Association would be able to attend these meetings.

The Secretary read correspondence from the Alberta Medical Association asking if some such arrangements could be made. It was the wish of the Executive Committee of the Manitoba Medical Association that if possible these arrangements should be made. In the resolution passed by the Executive at a previous meeting a preference for the last two weeks in September was indicated for the Annual Meeting. It was pointed out that it was the wish to have the Annual Meeting during the last three days of the week, but the President stated that if it was necessary to have it earlier in the week in order to accommodate the speakers, that this would be arranged. Dr. Routley prom-

ised to discuss the matter with the other provincial associations concerned.

Meeting of Secretaries of Provincial Associations.

Sometime ago a meeting of the Secretaries of the various provincial medical associations had been proposed, and a letter sent to all the men concerned. Some suggested that the meeting should be held in conjunction with the Annual Meeting of the Canadian Medical Association at Halifax in June.

This matter was discussed and the general opinion of the Executive Committee was that if such a meeting were held it would be advantageous to have it sometime apart from other business if a full benefit is to be obtained from it.

Professor E. V. McCollum.

Dr. Routley stated that he discussed this matter with the President and the Secretary and had been advised that Professor McCollum's visit had been a success. The Secretary was instructed to write the Canadian Medical Association thanking them for arranging this visit.

Cancer.

Dr. Routley explained that a Committee on Medical Research is being organized under the National Research Council, and he had suggested that any investigations of cancer cures that might be desired by any provincial government, should be carried out by this Committee. This would avoid overlapping and waste of effort. This suggestion was approved of by the Executive Committee of the Manitoba Medical Association.

Health Insurance and Rowell Royal Commission.

Dr. Routley referred to the brief submitted by the Canadian Medical Association to the Rowell Royal Commission. The question of group hospital insurance was brought up and he was asked if this scheme was being well received in Eastern Canada. He advised that in his opinion it was being well received and that the scheme in Kingston seemed to be working efficiently. The Secretary was given the name of the Committee administering this scheme in order that the Manitoba Medical Association might write for information.

Dr. Routley was asked also about the scheme of health insurance which was being carried out in Toronto. He stated that this was under the auspices of the Ontario Medical Association. The practitioners were being paid a full scale of fees; free choice of doctor was allowed; the doctors were paid for services rendered and the service covered the whole field of medical care, including hospitalization, confinements and operations.

Membership of the Canadian Medical Association in Manitoba.

Dr. Routley asked if the Manitoba Medical Association *Review* might give some publicity to the advantages to practitioners of belonging to

the Canadian Medical Association. The Executive agreed and were in favour of any publicity which would be of assistance.

Post-Graduate Work in England.

Dr. Routley advised that the Canadian Medical Association hoped to be able to make some definite arrangements for post-graduate work for limited groups in certain defined specialties.

Exchange of House Surgeons with Germany.

A suggestion had been received from Germany that House Surgeons might be exchanged between Canada and Germany. It was suggested by the Executive Committee that under the present conditions this proposal might be dropped.

Book on Poliomyelitis.

The Department of Health at Ottawa had suggested that the Canadian Medical Association might prepare a book on Poliomyelitis. The opinion of the Executive Committee of the Manitoba Medical Association appeared to be that any such publication would only be a repetition of literature already available.

Canadian Medical Institute Examinations.

Dr. Routley advised that examinations under the Life Extension Institute could now be made by any doctor and not only those on the approved list. It was suggested by the Executive Committee that a statement to this effect should be put on the form which was given to the person applying for the examination.

Letter from Department of Health re. Representation from the Manitoba Medical Association on Board of Arbitration to be Set Up in Municipality of Brenda.

The Secretary read the correspondence from the Deputy Minister of Health of Manitoba and explained what was required. It was moved by Dr. W. W. Musgrove, seconded by Dr. W. G. Campbell: THAT Dr. F. G. McGuinness be appointed the representative of the Manitoba Medical Association on this Board of Arbitration, and that if he was unable to act that the President and Secretary should name an alternative. —Carried.

Letter from Dr. Braunstein.

It was moved by Dr. W. W. Musgrove, seconded by Dr. O. C. Trainor: THAT this letter be filed. —Carried.

In connection with correspondence from the Canadian Medical Association, at the present time it is the custom to send these direct to members of Committees of the Canadian Medical Association. The President suggested that if such correspondence were sent to the Secretary of the Manitoba Medical Association, that they could then be referred to the member of the Committee of the Canadian Medical Association, or if this were not possible that if a copy were sent to the Secretary of the Manitoba Medical Association on the same date that it would enable the Executive Committee to keep in touch with the proceedings.

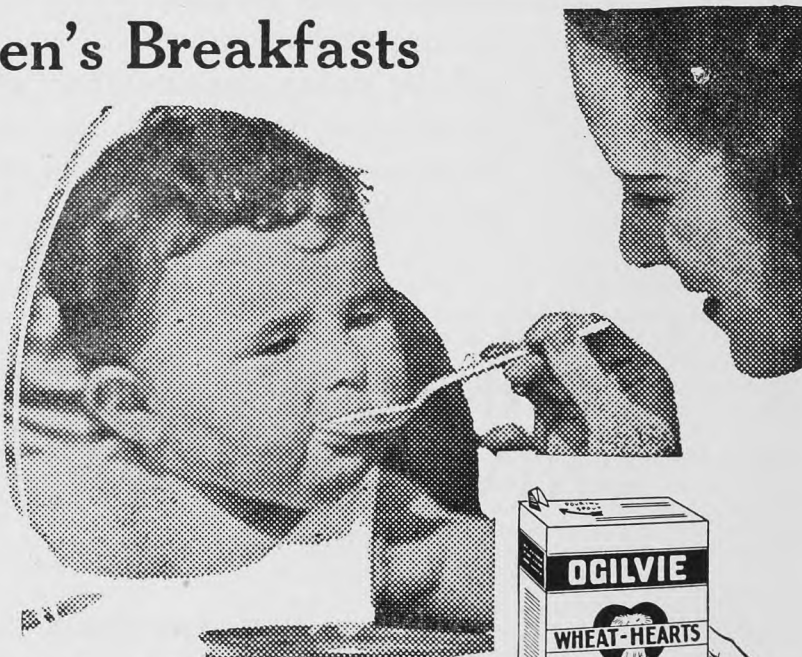
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NEWS ITEMS

PREVENTION OF COMMON SKIN AFFECTIONS OF EARLY CHILDHOOD

The following is an article by Frances Pascher, taken from the publication, "Preventive Medicine."

"Preventive medicine plays a role in dermatologic practice not only in the contagious disease of the skin but also in averting dangerous sequelae that threaten to complicate some of the non-infectious conditions.

COMMUNICABLE DISEASES

(a) IMPETIGO CONTAGIOSA

Among the contagious diseases, impetigo neonatorum (impetigo contagiosa, impetigo bullosa) is of primary importance because of its highly infectious character and the difficulties that are encountered in attempting to eradicate the disease once it has gained a foothold in a nursery. Furthermore, while in most instances, the lesions are few in number, the eruption may at times become sufficiently extensive to endanger the life of the individual (pemphigus neonatorum).

The following are some of the methods that have been employed to prevent the outbreak of the disease:

Chadwell (1) reported extraordinary success over a period of three years with the routine application of 5 per cent. ammoniated mercury as an inunction before the infants were allowed to leave the delivery room. A modification of this technique was suggested by Guy and Jacob (2), who substituted 2 per cent. ammoniated mercury which they found to be just as effectual and at the same time reduced the incidence of mercurial dermatitis. Immediately after delivery the infants were cleansed with sterile liquid petrolatum, then thoroughly with 2 per cent. ammoniated mercury from head to toe. After admission to the nursery daily cleansing was carried out with sterile cottonseed oil.

Bacteriophage rubs on the first and fifth day after delivery have also been found useful in reducing the incidence of impetigo (3).

It has been shown that the unit system of isolation technique is much superior to a centralized system in preventing the spread of the disease (4). In the former system individual equipment is used for each baby and all nursing care is carried out within this unit, whereas in the latter, group equipment is employed. Wherever the unit system is found impractical because of economic factors or lack of space, the centralized system may be made acceptable only if strict isolation of a suspect is immediately carried out.

(b) SCABIES

Scabies is a contagious disease of the skin caused by the itch mite *Acarus scabiei* that is transmitted either by direct contact or through mediate objects. Successful eradication of the disease depends not only on thorough treatment of the affected individual but also of all contacts showing signs or symptoms of the condition. The host may become reinfected repeatedly after each course of treatment unless the practice is strictly observed. In institutions, inspection of all contacts should be carried out at intervals, and all underwear, night clothes and bed clothes should be thoroughly sterilized when discarded.

Animal scabies in humans was recognized as early as the seventeenth century. It may be acquired through contact with infested animals, especially cats, dogs, and birds (5, 6). Sulzberger and Kaminstein (7) recently reported the occurrence of avian scabies in two families contracted from their infected canaries. A very interesting feature in one of these cases was

that the infestation persisted even after the pet had died. Inspection revealed that the cage used by the bird harbored the living insects three months after its occupant had departed and was the source of persistent reinfection.

(c) RINGWORM

Transmission of *tinea corporis*, *tinea capitis*, and dermatophytosis is very readily controlled by observing the customary rules of hygiene, e.g., thorough cleanliness, sterilization of clothing, and washing of toys. Children should not be allowed to chase about barefooted on beaches, in pools, or on bathroom or bedroom floors since fungi are readily picked up in this manner.

The proper management of *tinea capitis* deserves mention. One meets with two main clinical varieties of ringworm of the scalp. The human variety, characterized by fairly well defined round, coin sized, scaly patches of partial alopecia with short broken off hairs, and as a rule with a negligible degree of inflammatory reaction. This type of ringworm is caused by the *microsporon audouini*. Successful eradication depends on complete depilation of the infested hair which invariably requires the use of x-ray therapy.

The kerion type of ringworm caused by the *microsporon lanosum* is contracted, as a rule, through contact with infected pets. In these cases the inflammatory response is quite intense, giving rise to a boggy, circumscribed tumefaction, usually in one portion of the scalp about the size of a hen's egg with loss of hair and exudation of a seropurulent fluid from the follicular orifices of the involved portion. Kerion celsi is extremely amenable to antiparasiticides and may be completely eradicated by thorough applications of iodine or mercury. Since the depilation of hair by x-ray may be attended by serious sequelae (except in expert hands) e.g., permanent alopecia and radio-dermatitis, it is most desirable to avoid using this method unless specifically indicated.

NON-COMMUNICABLE DISEASES

(a) INFANTILE ECZEMA

Infantile eczema is the most frequent dermatosis seen in early childhood. Although the prophylactic measures that can be taken may be theoretical, and perhaps controversial, it is worth our while to grasp at every opportunity to allay this uncomfortable and often unsightly dermatosis. The steps that may be taken to prevent "allergic eczema" as well as other allergic manifestations have recently been reviewed in a very interesting paper by Glaser and Landau (8).

The advisability of marriage of allergic individuals is questioned, since it is known that the allergic constitution is inherited. Vaughan's (9) statistics show that when the inheritance is both maternal and paternal, 90 per cent. of the offspring develop allergic symptoms during the first decade.

It is suggested that the diet of allergic mothers should be so regulated during pregnancy and lactation as to exclude proteins to which there is a known familial sensitivity, and also to avoid excessive ingestion of any one protein. This is based on the work of Ratner (10), and Hill and Sulzberger (11).

The diet of the allergic or potentially allergic child should also be varied so as to avoid emphasis on any one food. Since food whims may be the expression of an intolerance to certain proteins they must not be dismissed lightly as behavior traits. Although egg is an important food in any infant's dietary, it must be introduced with caution, preferably after the first year. In order that adequate amounts of vitamins A, C, and D may be provided in the event of sensitivity to orange and tomato juice or to cod liver oil, and pineapple juice, carotene in oil and drisdol may be substituted.

The child's environment should be rendered as free as possible of sensitizing inhalants, e.g., silks, wools, furs, hair, feathers, orris root, and pyrethrum. Cotton clothing is most desirable and bedding should be made of synthetic "non-allergic" materials or kapok.

Although the prophylaxis of eczema is far from adequate, one fact must never be forgotten. It is dangerous to vaccinate a child with eczema or any other eruption. Cases of severe vaccina terminating fatally have been reported (12).

(b) MELANOMATA—BENIGN AND MALIGNANT

Every pediatrician, dermatologist, and general practitioner is called upon from time to time to treat or to advise as to the proper management of pigmentary nevi. It has been estimated that over 90 per cent. of individuals (13) are born with or develop nevi within the first two years of life. Two major problems come up for consideration:

1. Shall all benign melanomata be removed prophylactically to avoid the danger of malignant degeneration and what is the proper technique?

2. What are the signs of malignant change in a melanoma and what is the proper management?

Unfortunately the answers to some of these questions are not clear-cut and will remain debatable until our experience widens.

Removal of all pigmentary nevi as a routine procedure is not advisable since the incidence of malignant melanoma is quite small compared with the great frequency with which one encounters benign lesions. Furthermore, it is known that a malignant melanoma may arise in the absence of any apparent congenital abnormality or in a non-pigmented nevus. However, if the pigmented lesion is located in an area of predilection for malignant melanoma or in an area subjected to repeated and frequent irritation, intervention should be seriously considered. More than 50 per cent. of malignant melanomata reported have occurred on the head and lower extremities, particularly the feet. Coal black, bluish black or slate colored nevi are particularly hazardous although changes even in light brown and hairy nevi have been observed. Once removal is decided upon destruction must be complete and should include a zone of surrounding normal tissue. The methods of choice used by Klauder (14) and others are electrocauterization and electrodesiccation. Wide and deep surgical excision may also be used.

Malignant changes may occur at any age and have been reported as early as eight months (15). The symptoms of malignancy occur as a rule in the following order:

1. Increase in the size of the lesion with elevation of the entire patch or a portion of it.
2. Increase in pigmentation giving as a rule a striking coal black appearance.
3. Bleeding and superficial ulceration.
4. Enlargement of the regional lymph nodes.
5. Melanuria. This finding has been considered pathognomonic of malignant change in melanomata, but has also been reported in hepatic cirrhosis and subacute hepatitis.

Surgical excision has been followed by such a high incidence of recurrence and so frequently by immediate dissemination of the growth that the advisability of intervention has been seriously doubted by some dermatologists. Butterworth and Klauder (16) consider excision by electrosurgery combined with irradiation with heavily filtered roentgen rays the treatment of choice. At least 3 cm. of normal tissue around the lesion must be removed besides all tissue down to and including the fascial covering of the muscles. This is followed by X-ray treatment of the operative site and the regional lymphatics.

One wishes that the prophylaxis of many more dermatologic ailments were known or better understood. The advances in preventive medicine have been so

great, that one may look to the future with eagerness and confidence.

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COMMUNICABLE DISEASES REPORTED Urban and Rural - February, 1938.

Mumps: Total 363—Brandon 240, Winnipeg 66, Ethelbert 13, Unorganized 7, Morton 4, Blanshard 1, Whitehead 1 (Late Reported: January, Brandon 24, Ethelbert 3, Morton 4).

Chickenpox: Total 212—Winnipeg 145, Kildonan West 12, Clanwilliam 10, Hamiota Rural 9, Hanover 3, Kildonan East 2, Brandon 2, St. James 2, Arthur 1, Portage Rural 1, St. Francois Xavier 1, The Pas 1 (Late Reported: January, Lawrence 12, Kildonan East 5, Clanwilliam 1, Hanover 1, St. Boniface 3, Unorganized 1).

Measles: Total 135—Portage Rural 44, Portage City 42, Winnipeg 7, Emerson 6, Lorne 4, Oakland 3, Norfolk North 2, St. James 1 (Late Reported: January, Portage Rural 21, Portage City 3, Rosburn Rural 1).

Scarlet Fever: Total 130—Winnipeg 25, Brandon 14, Whitehead 14, Unorganized 9, Bolton 7, Franklin 7, Sifton 6, Edward 5, Arthur 4, Albert 3, Dufferin 3, Elton 3, Macdonald 3, St. Francois Xavier 3, Tuxedo 3, Flin Flon 2, Melita 2, Hillsburg 1, Morris Rural 1, Selkirk 1, Shell River 1, St. James 1, St. Boniface 1 (Late Reported: January, Elton 4, Brandon 2, Charleswood 1, Clanwilliam 1, Minnedosa 1, Sifton 1, Unorganized 1).

Whooping Cough: Total 66—Flin Flon 11, Winnipeg 11, Hanover 8, Blanshard 5, Brandon 5, Gilbert Plains Village 3, Gilbert Plains Rural 3, Roblin Town 2, St. Vital 1 (Late Reported: January, Flin Flon 9, Brandon 4, Grey 1, Portage Rural 1, St. Boniface 1, Westbourne 1).

Tuberculosis: Total 33—Unorganized 7, Winnipeg 6, The Pas 3, Ethelbert 2, Bifrost 1, Brandon 1, Brokenhead 1, Dauphin Town 1, Gimli Rural 1, Kildonan East 1, Kildonan North 1, LaBroquerie 1, Lorne 1, Norfolk North 1, Portage City 1, Rockwood 1, Selkirk 1, St. Boniface 1, Woodlea 1.

Erysipelas: Total 6—Winnipeg 3, Edward 1, St. Boniface 1 (Late Reported: January, Argyle 1).

Diphtheria: Total 5—Carman 1, Old Kildonan 1, Shell River 1, St. Vital 1, Unorganized 1.

Influenza: Total 4—Winnipeg 1 (Late Reported: January, Brokenhead 1, Gimli Village 1, Pembina 1).

German Measles: Total 2—Pipestone 2.

Anterior Poliomyelitis: Total 1—(Late Reported: January, Kildonan East 1).

Puerperal Fever: Total 1—Lawrence 1.

Paratyphoid: Total 1—Winnipeg 1.

Venereal Diseases Reported: Total 146—Gonorrhoea 80, Syphilis 66.

Medical Library University of Manitoba

Current Medical Literature

To the Medical Men of Manitoba:

The Library of the Faculty of Medicine is desirous of compiling a "Union List" of Periodicals or Serials, on file in the province and city of Winnipeg. This work has been authorized by the Library Committee, and The Junior League of Winnipeg has kindly offered to assist the Librarians in carrying out the survey.

In the near future, a member of The Junior League will call at the offices of the city physicians, leaving one of the forms, while those in the country will later receive theirs by mail.

The co-operation of all physicians is requested to make this survey a complete one, and one which will be of great value to the medical library, and also to the profession.

LENNOX G. BELL, M.D.
Secretary, Library Committee,
Faculty of Medicine,

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OBITUARY

DR. DANIEL H. MCCALMAN

Dr. Daniel H. McCalman died suddenly on March 5th, leaving behind him a record of a singularly active and useful life. For the last few years his health had been indifferent, but apparently he had improved, and on February 1st he was present at the annual meeting of the Sanatorium Board of Manitoba and took part in the discussion.

He was born near Barrie, Ontario, in 1861, and came to Manitoba in 1880. He taught school in Emerson and then graduated in Arts from St. John's College, Winnipeg. He attended Normal School, and in 1887 became School Inspector. Eight years later he entered the Manitoba Medical College, where he had a brilliant academic career. In 1902 he became Professor of Hygiene in the Manitoba Medical College, in 1905 Lecturer in Obstetrics, and in 1907 Professor of Obstetrics, a post which he held for twenty years, then becoming Professor Emeritus. In 1905 he was appointed Obstetrician to the Winnipeg General Hospital and resigned in 1922, when he was appointed a member of the Honorary Consulting Staff.

With his friends, Dr. Gordon Bell and Dr. E. W. Montgomery, he took a keen interest in public health matters and in 1923 he became chairman of the Manitoba Board of Health, with which he was long associated. He was a Past President of Manitoba College of Physicians and Surgeons and a Trustee of the Gordon Bell Memorial Fund. He became a member of the Sanatorium Board of Manitoba in 1930.

His keen mind, singleness of purpose and devotion to duty made him a very valuable member of the medical profession both as a teacher and administrator.

The first edition of the London Pharmacopœia was published in 1618.

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